dependent), or by other third parties such as a State.

(i) Regarding the option in paragraph (f)(1) of this section, MA organizations may not impose a charge on beneficiaries for the election of this option.

(ii) An enrollee may opt to make a direct payment of premium to the plan.

(g) *Prohibition on improper billing of premiums.* MA organizations shall not bill an enrollee for a premium payment period if the enrollee has had the premium for that period withheld from his or her Social Security, Railroad Retirement Board or Office of Personnel Management check.

(h) *Retroactive collection of premiums.* In circumstances where retroactive collection of premium amounts is necessary and the enrollee is without fault in creating the premium arrearage, the Medicare Advantage organization shall offer the enrollee the option of payment either by lump sum, by equal monthly installment spread out over at least the same period for which the premiums were due, or through other arrangements mutually acceptable to the enrollee and the Medicare Advantage organization. For monthly installments, for example, if 7 months of premiums are due, the member would have at least 7 months to repay.

[63 FR 18134, Apr. 14, 1998, as amended at 74 FR 1541, Jan. 12, 2009]

§422.264 Calculation of savings.

(a) *Computation of risk adjusted bids and benchmarks.* (1) *The risk adjusted MA statutory non-drug monthly bid amount* is the unadjusted plan bid amount for coverage of original Medicare benefits (defined at §422.254), adjusted using the factors described in paragraph (c) of this section for local plans and paragraph (e) of this section for regional plans.

(2) The *risk adjusted MA area-specific non-drug monthly benchmark amount* is the unadjusted benchmark amount for coverage of original Medicare benefits by a local MA plan (defined at §422.258), adjusted using the factors described in paragraph (c) of this section.

(3) The *risk adjusted MA region-specific non-drug monthly benchmark amount* is the unadjusted benchmark for coverage of original Medicare benefits amount by a regional MA plan (defined at §422.258) adjusted using the factors described in paragraph (e) of this section.

(b) *Computation of savings for MA local plans.* The average per capita monthly savings for an MA local plan is 100 percent of the difference between the plan's risk-adjusted statutory non-drug monthly bid amount (described in paragraph (a)(1) of this section) and the plan's risk-adjusted area-specific non-drug monthly benchmark amount (described in paragraph (a)(2) of this section). Plans with bids equal to or greater than plan benchmarks will have zero savings.

(c) *Risk adjustment factors for determination of savings for local plans.* CMS will publish the first Monday in April before the upcoming calendar year the risk adjustment factors described in paragraph (c)(1) or (c)(2) of this section determined for the purpose of calculating savings amounts for MA local plans.

(1) For the purpose of calculating savings for MA local plans CMS has the authority to apply risk adjustment factors that are plan-specific average risk adjustment factors, Statewide average risk adjustment factors, or factors determined on a basis other than plan-specific factors or Statewide average factors.

(2) In the event that CMS applies Statewide average risk adjustment factors, the statewide factor for each State is the average of the risk factors calculated under §422.308(c), based on all enrollees in MA local plans in that State in the previous year. In the case of a State in which no local MA plan was offered in the previous year, CMS will estimate an average and may base this average on average risk adjustment factors applied to comparable States or applied on a national basis.

(d) *Computation of savings for MA regional plans.* The average per capita monthly savings for an MA regional plan and year is 100 percent of the difference between the plan's risk-adjusted statutory non-drug monthly bid amount (described in paragraph (a)(1) of this section) and the plan's risk-adjusted region-specific non-drug monthly benchmark amount (described in paragraph (a)(3) of this section), using the risk adjustment factors described in paragraph (e) of this section. Plans

with bids equal to or greater than plan benchmarks will have zero savings.

(e) *Risk adjustment factors for determination of savings for regional plans.* CMS will publish the first Monday in April before the upcoming calendar year the risk adjustment factors described in paragraph (e)(1)and (e)(2) of this section determined for the purpose of calculating savings amounts for MA regional plans.

(1) For the purpose of calculating savings for MA regional plans, CMS has the authority to apply risk adjustment factors that are plan-specific average risk adjustment factors, Region-wide average risk adjustment factors, or factors determined on a basis other than MA regions.

(2) In the event that CMS applies region-wide average risk adjustment factors, the region-wide factor for each MA region is the average of the risk factors calculated under §422.308(c), based on all enrollees in MA regional plans in that region in the previous year. In the case of a region in which no regional plan was offered in the previous year, CMS will estimate an average and may base this average on average risk adjustment factors applied to comparable regions or applied on a national basis.

§422.266 Beneficiary rebates.

(a) *General rule.* An MA organization must provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in §422.264(b) for MA local plans and §422.264(d) for MA regional plans.

(b) *Form of rebate.* The rebate required under this paragraph must be provided by crediting the rebate amount to one or more of the following:

(1) *Supplemental health care benefits.* MA organizations may apply all or some portion of the rebate for a plan toward payment for non-drug supplemental health care benefits for enrollees as described in §422.102, which may include the reduction of cost sharing for benefits under original Medicare and additional health care benefits that are not benefits under original Medicare. MA organizations also may apply all or some portion of the rebate for a plan toward payment for supplemental drug coverage described at §423.104(f)(1)(ii), which may include reduction in cost sharing and coverage of drugs not covered under Part D. The rebate, or portion of rebate, applied toward supplemental benefits may only be applied to a mandatory supplemental benefit, and cannot be used to fund an optional supplemental benefit.

(2) *Payment of premium for prescription drug coverage.* MA organizations that offer a prescription drug benefit may credit some or all of the rebate toward reduction of the MA monthly prescription drug beneficiary premium.

(3) *Payment toward Part B premium.* MA organizations may credit some or all of the rebate toward reduction of the Medicare Part B premium (determined without regard to the application of subsections (b), (h), and (i) of section 1839 of the Act).

(c) *Disclosure relating to rebates.* MA organizations must disclose to CMS information on the amount of the rebate provided, as required at §422.254(d). MA organizations must distinguish, for each MA plan, the amount of rebate applied to enhance original Medicare benefits from the amount of rebate applied to enhance Part D benefits.

§422.270 Incorrect collections of premiums and cost-sharing.

(a) *Definitions.* As used in this section-

(1) Amounts incorrectly collected-

(i) Means amounts that-

(A) Exceed the limits approved under §422.262;

(B) In the case of an MA private fee-for-service plan, exceed the MA monthly basic beneficiary premium or the MA monthly supplemental premium submitted under §422.262; and

(C) In the case of an MA MSA plan, exceed the MA monthly beneficiary supplemental premium submitted under §422.262, or exceed permissible cost sharing amounts after the deductible has been met per §422.103; and

(ii) Includes amounts collected from an enrollee who was believed to be entitled to Medicare benefits but was later found not to be entitled.

(2) *Other amounts due* are amounts due for services that were—